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Some Conclusions Drawn from Experiences in

PELVIC SURGERY

BY

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With an increasing experience in operating work, one soon comes to the conclusion that simplicity is a factor of greatest importance. Elaborate preparatory arrangements for operations are not always possible—in fact, not necessary, except in extraordinary cases. The improvement in statistics to-day is due more to scrupulous attention to cleanliness than to manual dexterity. We should adopt a system in our work and carry out the same in every detail, if success is to crown our surgical efforts.

Eliminating unnecessary details, the following technique has been used for the past few years, with satisfaction: When possible, two hours before the operation the patient is given on an empty stomach 30 or 40 grains of bismuth subnitrate. This has the happy effect of relieving nearly all gaseous distension, the intestines presenting a collapsed appearance. Instruments are boiled in a 1 per cent soda solution for a few minutes, the ligatures, previously sterilized by boiling in alcohol, are boiled again in pure water, together with the cotton, gauze, pad, and sponges. The patient, thoroughly cleansed, is covered with sterilized operating-sheets, all the surroundings being covered with the same. These sheets are in size 1 yard square, a generous supply being carried to each operation, even in my hospital work, as the system is not disturbed when operations are performed in emergency in the private dwellings of the well-to-do or in

alleys and attics. My good results attained in the presence of unclean and at times filthy surroundings are due in a measure to this procedure. These spread cloths are placed in position in the same manner and almost as quickly as a salvage corps would spread their tarpaulins.

The incision should be primarily short, and only enlarged to meet the demands of the case. It will be found that equally as good and complete work is accomplished through short incisions, with practice. When bismuth has been given before the operation, the intestines seldom interfere by showing a tendency to escape from the abdomen. Evisceration of the intestines is an accident that demands immediate attention. The simple towel method of reduction of escaping loops of intestines merits recommendation. Form a sack by slipping the edge of a small wet towel or square of gauze under the margins of the incision, and reduce the mass as you would a hernia by manipulation. Unnecessary manipulation of the omentum is to be avoided, adding materially to the shock of the operation by reason of the peculiar nerve-supply connection with the abdominal sympathetic ganglia. Avoid ligating *en masse*, if posible, for the same reason.

In enucleating pus-tubes and ovarian abscesses, a starting-point is best secured posteriorly, the difficulties being materially lessened. More than once have I seen poky operators groping about like the blind, starting at this point, then at that, wasting valuable time in efforts at enucleation. The patient in other hands might have been placed back in bed and started on the road to convalescence but for ignorance of this important point. Rapid and at the same time careful work is a factor of the greatest importance in all surgical work, especially when intra-abdominal.

It has been stated by those in high places and in authority that, "in these days of anæsthesia time is of

little importance." I protest against such teaching. The anæsthetic *per se* is a dangerous element. Contrast the results of rapid and at the same time careful operators with the slow, hesitating methods of others.

The subject of drainage has been given much thought. The tendency at present is to do away with the tube. I am afraid we cannot. The world's best records have been made by operators using the tube. Why should we then discard it? An operator, self-styled, with an experience of three cases of pelvic surgery, once told me he never used the tube. What right had he to express an opinion sweepingly condemning its use? When to drain and when not to drain cannot be properly and definitely answered to the satisfaction of all. Personally, I believe in draining: (1) All acute and chronic septic cases. (2) When numerous adhesions are present, especially adhesions presenting broad surfaces that bleed freely. (3) Where the abdomen has been flushed in the presence of hemorrhage. (4) Always in extra-uterine pregnancy cases.

Is it advisable to flush the abdomen? Individually, I am most emphatically in favor of flushing, if indications for sponging are presented as an alternative. A free flushing occasions less insult to the peritoneum than a sponging of pus and other fluids of a doubtful nature. It is not reasonable to believe that a thorough sponging is less irritating to the delicate serosa than a simple irrigation. The idea of disseminating microörganisms by irrigating fluids is offset by the vaccination of the delicate peritoneal surface with a sponge laden with the same germs, if germs be present.

The gauze tamponade on more than one occasion has served a good purpose. Several lives were probably saved by its application. I have never hesitated to use the tamponade when the choice lay between it and tedious, difficult multiple ligation of sharply bleeding points. A

5 per cent iodoform gauze is used, simply passing from the original package one end of the gauze roll into the most dependent part and tucking in at the irregular spaces. In this manner more than a yard has been frequently used, the same being left for some hours, often for several days.

Simplicity of method in closing the abdomen seems most proper. Why spend only a few moments in performing an operation and thirty or forty minutes in closing the incision, using the theoretical plan of some idealist or arm-chair authority, lacking practical experience? With sutures cut long, the half-curved Hagedorn needle is introduced less than half an inch from the skin margin, penetrating it, and is passed well out, including plenty of muscle. The needle point is then carried in, to within less than a fourth of an inch from the cut peritoneal margin, carried through, using the reverse order on the opposite side. The sutures are introduced a trifle over half an inch apart, no inversion of skin and eversion of peritoneum taking place. Immediately before closure of the incision sufficient irrigating fluid is often poured into the abdomen to float the intestines into natural position, the omentum always being carefully adjusted.

Stitch-hole abscesses merit more attention than is usually paid them. Their presence causes great discomfort to the patient as an immediate effect; the more remote effect, by their burrowing and weakening the line of incision, making them directly causative agents of ventral hernia. A post-operative hernia is the opprobrium of the surgeon, the source of dissatisfaction, and engenderer of bitter feelings on the part of a patient who might have been grateful. Do a section and save a life, let the operation be followed by a hernia, and the fact of a life having been saved is forgotten. Such patients will go forth and advertise the misfortune to your discredit. I have had such hernias, and I think every honest operator will say the same, no matter what method of closing the abdomen

has been adopted. Whenever such cases are met with, advise immediate closure, relieving the discomfort of the patient, and also stop a bad advertisement. Some comfort may be derived from the fact that this new field is opened up for the exercise of our art, in the closure of post-operative hernias. Indeed, they are so numerous that one could make a lucrative specialty of the same. It is well to operate early in these cases, before great change has occurred in the tissues, especially in the muscles. The technique of operation in ventral hernias is simple. an elliptical *excision* of the line of incision, including a little of the surrounding tissues, and all redundant skin, accurate coaptation, and enfored recumbency for three to five weeks. The results attained were all that could be desired in the cases operated on.

A careful study of cases of pyosalpingitis and pelvic collections of pus only confirms my belief that the rational treatment is by abdominal section and complete removal of the disease. Vaginal incision in these cases has but a very contracted place in the surgery of pus in the pelvic basin, and, to my mind, is unsurgical.

The removal of the uterus with appendages for affections other than cancerous disease, or where definite tumors are not present (such as diseases of acute or chronic inflammatory nature), is taking a step too far. It is carrying out a surgical exercise to an unwarranted extent, and merits condemnation.

Concerning the appendix and the diseases of the iliac fossa, my conclusions are to the highest degree radical. I have no regrets to offer for the cases of appendicitis operated upon, many regrets for some not operated upon. The sooner all cases of appendicitis are subjected to operation the better. Osler dismisses the subject of medical treatment in this disease with the frank statement that there is no medical treatment, and this is probably the correct view to take. When early operation

becomes the rule, surgery will not come in for so much reproach on the part of the laity. The reproach is merited at present, owing to the hesitancy and inactivity of those who believe, like Micawber, in waiting for "something to turn up." The advocates of delay until decided symptoms set in frequently procrastinate until the fate of their patient is settled. Waiting for pus, perforation, or urgent symptoms is worthy of those believing in Christian science and a cure by faith. When the profession recognizes peritonitis not as the disease, but only as a symptom, then, and only then, will the mortality of the disease be where it should be. It is far better to make exploratory incisions than to assume the risks of delay. To presume that this case or that will get well without operation is an injustice to the patient, for no one can tell the outcome in any given case of appendicitis.